Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-3663-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was denied a 2nd time on 6/27/14 indicating "this is a bundled or on covered procedure based on Medicare guidelines; No separate payment allowed"

Amount in Dispute: $99.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed in the amount of $59.58 was issued on 9/23/14 check number 0112728764."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2014	Outpatient Laboratory Services	$99.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the respondent pay in accordance with Division rules?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (e) The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and, (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service. The MAR calculations is a follows;

Procedure Code	Billed Amount	MAR (Medicare Fee Schedule Amount x 125% No Technical component)	Amount Paid by Carrier	Amount Due
36415	25.00	$3.00 x 125% = $3.75	3.26	$0.00
80048	119.50	$11.54 x 125% = $14.43	18.20	$0.00
85025	106.50	$10.61 x 125% = $13.26	16.73	$0.00
85610	88.80	$5.37 x 125% = $6.71	8.47	$0.00
85730	88.50	$8.19 x 125% = $10.24	12.92	$0.00
Total	$428.00	$48.39	$59.58	$0.00

2. The total allowable for services in dispute is $48.39. The carrier paid $59.58. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.